ATTACHMENT IV

_____ REGIONAL SUPPORT NETWORK (AUTHOR. CODE # _____)
EXTENSION REQUEST FOR HOSPITALIZATION

NAME:_____ COUNTY OF RESIDENCE:_____

PATIENT IDENTIFICATION CODE (PIC):_____ BIRTHDATE:_____

INPATIENT FACILITY:_____

PRINCIPAL DIAGNOSIS:_____

OTHER DIAGNOSES:_____

_____

PRINCIPAL DIAGNOSTIC CODE:_____ DATE OF ADMISSION:_____
(ICD-9 CODES)
MAXIMUM LENGTH OF STAY BY DIAGNOSIS (PAS days):_____through_____

REASON FOR EXTENSION REQUEST: (Provide the following information below or in attached documents: Current problems requiring inpatient care, progress toward treatment goals, current medications, medical condition, current discharge plan, how will continued inpatient care improve or prevent deterioration of condition, why less restrictive care is not appropriate.)

_____
_____
_____
_____
_____
_____

NUMBER OF EXTENSION DAYS REQUESTED:_____days through_____

HOSPITAL REVIEWER SIGNATURE:_____DATE:_____

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NUMBER OF EXTENSION DAYS APPROVED: _____days through_____

NUMBER OF ADMINISTRATIVE DAYS APPROVED:_____days through_____

NUMBER OF EXTENSION DAYS DENIED:_____days through_____

AUTHORIZING SIGNATURE OF RSN:

_____**DATE:_____**

COMMENTS:_____
_____
_____

Send this form to: ____Regional Support Network
____

Distribution: County, RSN, Hospital, ___
12/2000